patient was supposed to be in splendid condition. She died instantly, no doubt as the result of a clot in the pulmonary vessels, though no post-mortem was held. Most of the cases in which embolism occurs are simple in character, and for that reason the surgeon is apt to allow the patient early liberty. A similar variety of sudden death occurs after undue exertion during pneumonia.

Dr. Henry R. Wharton mentioned a case in which he performed Schede's operation for varicose veins of the leg. The patient recovered from the anæsthetic, but in five hours developed shortness of breath and soon died. There was in this case some question as to whether there was pulmonary or cardiac embolism, as no post-mortem examination was made.

Dr. Le Conte added that cases of pulmonary embolus might be divided into two groups, the septic and the non-septic; and these again into large emboli and small ones. In some cases where the embolus is aseptic and small, one of the smaller branches of the pulmonary artery may alone be occluded, and the patient may present symptoms not dissimilar to syncope. There will be a rapid, feeble pulse, shallow respiration, sweating, and usually pain in the lung. Such cases almost invariably recover, the attending surgeon perhaps having entirely overlooked the fact that embolus has taken place. In other instances the non-septic thrombus may be so large that the entire pulmonary artery is occluded, and death is almost instantaneous.

In the septic group, if the primary thrombus is small and only a portion of the artery is occluded, the patient recovers from the immediate shock, to develop later a septic pneumonia or gangrene of the lung. In such cases, then, the patient does not die as a result of the occlusion of the vessel, but rather on account of the septic material which has been deposited in the lung.

COMPLETE INTESTINAL OBSTRUCTION FROM A BAND AND VOLVULUS OF THE ILEUM.

Dr. Robert G. Le Conte reported the case of a man, aged forty years, who was admitted to the Pennsylvania Hospital, July 18, 1904, with a history of four attacks of appendicitis since June, 1903, culminating in an attack in April, 1904, when a large abscess in the region of the appendix was opened, but without the removal of the appendix.

On July 14, 1904, he was again seized with nausea, vomiting, and great abdominal pain. There was great prostration. His bowels moved slightly the next day and again on the morning of admission, July 18. Vomiting was more or less constant and was of a greenish hue, but not until the evening of the 17th was there any offensive odor from the vomitus. On admission the patient was pale and haggard looking, very thin, vomiting of a projectile type, every half or three-quarters of an hour, material that was thin and stercoraceous. The abdomen was distended, rigid, universally tender, but most markedly so between the scar of the former operation and the umbilicus. Pulse weak and small; temperature normal. Diagnosis, obstruction from a band of adhesion.

The patient was immediately etherized and a four-inch incision made in the median line between the umbilicus and the pubes. The small intestine was found very much distended with numerous adhesions, the bowel being firmly adherent to the cicatrix of the previous operation. After breaking up some of the adhesions, a firm band was found compressing about three feet of the lower ileum, and this portion of the gut had taken one twist to the right. While breaking through this band and further separating the adherent gut from the abdominal wall, the friable bowel was torn. Through this perforation the liquid contents of the bowel were evacuated; the rent was then sewn up and the abdomen flushed with warm sterile salt solution and closed without drainage. The patient's condition was so precarious that no attempt was made to find the head of the colon or to explore the appendiceal region. As the abdomen was being closed, an assistant passed a stomach-tube and washed out the stomach, removing in the neighborhood of a quart of stercoraceous material. Reaction following the operation was slow, but there was no further vomiting and the sensation of nausea gradually disappeared; the pulse improved in volume and strength. Five days after operation the patient again complained of severe pain in the old appendiceal scar. The temperature, which had been normal, rose to 101° F. Inspection of the abdomen showed that there was bulging over the lower portion of the old scar, with exquisite tenderness and redness of the skin. An incision was made into this and several ounces of grumous, grayish, foul-smelling material was evacuated. A rubber tube was inserted for drainage. This material was reported by the pathologist to be more or less structure-

less and without leucocytes, resembling in its characteristics fæcal material. The temperature immediately fell to normal, the pain disappeared, and there was no further discharge from the cicatrix. The convalescence from this time was uneventful, the median incision healing by primary union, and the cavity in the old scar by granulation. The patient was walking about by August 25, and was discharged from the hospital on the 29th of August in good condition with both cicatrices sound.

Dr. John B. Roberts had operated upon a similar case. The patient had had his appendix removed, and a short time later obstruction necessitated a second operation. One year later, when again suffering from obstruction, he came under the care of Dr. Roberts. Operation revealed a dense matting together of all the structures in the right iliac fossa. The intestine was kinked, a loop having passed beneath a constricting band and produced an intestinal hernia. The loop was drawn out of its bed and the patient recovered.

Dr. De Forest Willard had met with several cases of obstruction following operation for appendicitis, the obstruction developing from ten days to three weeks after operation, during healing of the wound. On three occasions Dr. Willard had opened the abdomen and found cicatricial bands. In one there were two bands, one inch apart, the division of which gave the desired relief. In the second, two feet of the intestines were shut off, requiring resection; the patient recovered. In the third case, adhesions were more extensive, and in freeing them the bowel was ruptured; this patient died on the second day. In a case of inflamed ovarian cyst followed by appendicitis and obstruction after operation the intestines were found so adherent that it was impossible to separate them. Death ensued. Considering the frequency of general peritonitis, it is a wonder that obstruction does not more often follow appendicitis operations.

Dr. Le Conte said, in closing, that when a constricting band alone is present the condition is a comparatively simple one to deal with. The lumen of the intestine is cut off, but the circulation in the constricted portion is not materially interfered with. When, however, volvulus occurs, the blood supply to the intestine is cut off in the mesentery, and thrombosis of the veins will take place if the condition exists for any length of time. Thrombosis of the mesenteric veins necessitates intestinal resection, and death will

follow in the majority of cases, as the patient's condition is usually so bad that a prolonged operative procedure cannot be safely undertaken. Of six or seven cases of volvulus personally seen by the reporter, the case reported this evening was the only one saved. It is difficult to understand how volvulus occurs when the intestine is free, but the mechanism is more simple when a portion of the gut is adherent, for we can readily understand how violent peristaltic movement, when suddenly checked by an adhesion, might throw a loop of intestine around this adhesion. The recorder's opinion was that in the case reported this evening the band had probably lasted for several days, gradually constricting the intestinal lumen, but that the volvulus had perhaps been present only a few hours, as there was no evidence of the formation of clot in the mesentery veins.

OSTEOMA OF THE ORBIT.

Dr. William J. Taylor presented a bony growth removed from the left orbit of a boy of sixteen. The operation was done at St. Agnes's Hospital on December 21, 1903. The boy had been under observation and treatment at the Eye Department under Dr. Shoot and Dr. Perkins, who have a very elaborate history of his ocular conditions. A careful X-ray study was made also of his head, as he desires to make a more detailed report of this case in the future. The left eyeball was pushed forward, downward, and outward by a mass growing in the orbit. The boy's mental condition was gradually becoming cloudy, he was irritable, his whole disposition had changed, and he was totally unlike his former self. There were, however, no definite symptoms which could localize any growth in the brain, nor had there been any palsies other than the difficulty with the ocular muscles, which seemed to be directly due to local pressure.

An incision was made along the upper border of the eyebrow, exposing a hard bony mass, which seemed to fill the whole of the orbit. The edge of the orbital ridge was thinned out and blended in with the outline of this irregular mass of bone, which was so hard and dense, that a chisel or gouge could make no impression upon it whatever. It was, therefore, necessary to cut away the whole of the orbital ridge, and in so doing the frontal sinus was opened, from which a large quantity of glairy material exuded.